elastic. During non-plague times, treatment can be as likely to take place off-site, where the trust is (and often where the trouble is) as it is to take place in our home base on Kedzie Avenue.[3] We offer ongoing psychotherapy process groups for students in their schools, including one designated for DACA and undocumented students, who have felt particularly vulnerable given increasingly pervasive anti-immigration rhetoric as well as public charge concerns that in general have made service access for the undocumented and tenuously documented exponentially more frightening. Therapeutic services for parents often begin in more familiar and accessible school spaces as well, which can function as a bridge to clinic-based interventions, while older adults, who may have limited mobility and an even more acute sense of vulnerability, participate in their senior living facilities. Relationships are developed sometimes quite literally on the streets—at festivals, community events, and our annual holiday giveaway of 100 kids' bikes, as well as at events that we host for the general public aimed at addressing threats to our neighborhoods. Our Acute Trauma Outreach Program extends our hand even further in an effort to facilitate respect and healing to families affected by gun violence, sexual trauma, and losses due to Covid. We recognize that it can sometimes take years before victims of violence, for instance, feel ready to access or re-access the parts of themselves that were shattered, but we work to adjust our tempo to theirs, meeting each person when and where we can, knowing we're all in it for the long haul. Integral to a psychotherapeutic process that facilitates saying the unsayable, we feel an imperative to reach the unreachable, those at the margins, who may not ever in their lives have had the opportunity to explore their distress as a form of expression worthy of respect, or to audition alternative symptoms that might more effectively facilitate connection and growth.

We celebrate the first decade of the Expanded Mental Health Services Act and believe that it has the potential to facilitate transformation in the lives of thousands by making quality treatment possible. Yet we know that not every center authorized by the Act will opt to contract with depth therapy-oriented organizations or even community-oriented ones, despite the community support needed simply to get a referendum on the ballot. And, of course, we walk the same delicate line that individual psychoanalytically oriented practitioners do, committed to constant self-examination lest our belief in a perspective that holds listening and a sensitivity to the particularities of internal and cultural meaning at its core itself become a universalist, prescriptive orthodoxy. What we can say at this point is that we at EMHS-NFP have had the privilege of witnessing the coming into being of a clinic that strives towards life and are the better for it. Further, we have seen the power of a psychodynamic vision to reach communities and individuals whose roots are seemingly far from those of psychoanalysis, and to watch how that distance is bridged through stories of pain and grief, healing and hope. We await Kedzie's "sibling" with optimism and anticipation, eager to participate in the transformations of a second community "under [whose] wrist is the pulse, and under [whose] ribs the heart of the people" (Sandburg, 1914). ▮

3. Sadly, some number of groups were disrupted during the height of the pandemic, and the emphasis turned temporarily to individual contact by phone and Zoom, some community and group Zoom services and events, support for out-of-school students and parents, and more intensive wellness-oriented interventions, including some financial support as well as more liaisons with other community agencies. Needless to say, our families were often hit harder than others in more affluent neighborhoods in the city and state, and our staff struggled to tolerate the reverberations of trauma on trauma.

REFERENCES

Bloom, M. (2018, November 7). *NW side is getting a community-funded mental health clinic thanks to overwhelming support of voters*. Block Club Chicago. https://blockclubchicago.org/2018/11/07/nw-side-is-getting-a-community-funded-mental-health-clinic-thanks-to-overwhelming-support-of-voters/

Quinn, M. (2018, September 27). *This is what happens when a city shuts down mental health clinics.* Governing. https://www.governing.com/archive/gov-chicago-mental-health.html

Sandburg, C. (1914). Chicago. *Poetry*, *3*(6).

Abandoning the Analytic Frame

Rossanna ECHEGOYÉN

In analytic practice, we are taught and trained to maintain a therapeutic frame and analytic identity, both of which can impede and interfere with engagement in community settings. This paper will explore ways in which we can adjust our analytic stance on a collective level in the service of community. In community psychoanalysis, the ability to be flexible, humble, and adaptive to the community environment is a call to action to shift the frame.

"Community psychoanalysis" is psychoanalysis outside the consultation room providing interventions to a group, agency, school, or organization. It is also a "way of working" that opens possibilities for connection and sustaining care for the most vulnerable populations, specifically the impoverished, the elderly, children, marginalized groups, and the mentally ill. In addition to that, it is a mode of intervention that is applied to the community at large, for example with police, hospitals, schools, or an intervention to a traumatic incident in a community.

What does it take to shift the paradigm to work beyond the consultation room? I have tried to explain this concept to many of my colleagues, and they are still befuddled by what exactly community psychoanalysis is and who exactly it serves. Is it psychoanalysis in marginalized communities? Yes. Is it at community mental health clinics? Yes. Is it interventions for hard-to-reach populations? Yes, it is all of these scenarios, but it is also the community at large—for example, providing a community intervention at a macro level to train police.

We can turn to Stuart Twemlow, who has written extensively on this subject and is known for his work with anti-bullying at a school: "A community analyst is required to exercise flexibility in technique and personal humility when embracing an analytic identity derived from a mode of action" (Twemlow, 2013). I discovered Dr. Mark Borg (2005), who uses an interpersonal perspective focused on transference/countertransference at an institutional level in his work with gang violence in Los Angeles. There are many more examples of analysts who contribute to scholarship and practice in the public sector. I encourage you to check out contributions by Ghislaine Boulanger, Patricia Gherovici, Ruth Lijtmaer, Ricardo Ainslie, George Bermúdez, and Judith Alpert. There are so many more to mention, but these analysts stand out as models of shifting our positionality.

I will be referring to "community" often and want to clarify that this is not just about working at a clinic in a low-income neighborhood. When I refer to community, I'm referring to any group of people that are part of a vulnerable group. My assertion is that community refers to populations that are hard to reach or are at risk of falling victim to gaps in care.

What is it that I mean by a frame? As we all come to practice, we adapt to different "frames" that are useful as containers (among other utilities) in a therapeutic dyad. As analysts, we shape our own frame that fits our theoretical persuasion, comfort level, countertransference/transference considerations, and practical considerations in the effort to hold and contain the treatment. In their co-edited book, Isaac Tylim and Adrienne Harris skillfully curated varied perspectives in *Reconsidering the Moveable Frame in Psychoanalysis* (2018), which is a compilation of theoretical orientations, explorations of the impact of social forces on the frame, challenges of flexibility of the frame, and varied experiences of creative uses of the frame in analytic treatment.

The frame acts as a boundary to hold patients who require mastery of a developmental task and are working through attachment

issues and other psychological concerns. As we all know, components of the frame include payments for sessions, frequency, vacation, the setting, the contract or agreement to provide care to our patients, and external elements of the setting. In this past year, we have all adjusted our frame due to Covid.

As we all know and experience in our training, the frame is aligned with our analytic stance, whatever that might be. An example: A patient frequently misses their session. Depending on your orientation or analytic stance, you may or may not reschedule the patient. You may or may not charge them the fee, schedule a make-up session, etc. Whatever your alliance, a boundaried analytic stance will not translate well in a community setting. Collective interventions require spontaneity and flexibility that do not work in tandem with the fixed "analytic frame" that we often incorporate into our private practices.

When the concept of the frame is utilized in a systems model, such as a social service agency, mental health clinic, or school, the frame is challenged by the competing forces of Medicaid regulations imposed on the institution of the clinic and the needs of the client. In my experience in community mental health settings, we were often challenged by frame issues such as patients arriving late to their sessions and missing their sessions at a high frequency, which led to discharging their cases preemptively before we could analyze what was transpiring clinically with them.

In a community setting, patients' lives are mired by multiple socio-political, socio-cultural, and socio-economic factors that set them up for failure when it comes to a rigid frame. Oftentimes, at the clinics where I've worked, I had patients on my caseload who would be pathologized as "chaotic" patients due to their poor attendance and the pathologization of their life circumstances. This can manifest in the therapist being withholding, which can be interpreted by the patient as the therapist being dismissive, and therefore the patient is unseen, unheard, and invalidated.

When we are working with hard-to-reach populations, this mode of therapeutic action of holding the frame perpetuates whiteness in a clinic or community setting. By whiteness, I am specifically referring to white supremacist ideologies that subjugate the most vulnerable to remain in power. By whiteness, I'm speaking to the rigidity of clinicians who are unable to adapt to a person's suffering due to maintaining a position of power in the clinical situation. The burden of systems shutting them out of society (their Medicaid case was closed; they were getting evicted from public housing; they do not have bus fare to get to the clinic) would spill into the treatment room. These are all examples of whiteness and white supremacy.

On a macro level, more specifically at an institutional level, there was an understanding and explicit statements made by the directors of the clinic that we were dependent on government contracts, and any misstep could close our doors. Thus, community mental health clinics that rely on government funding via Medicaid/Medicare contracts and program-specific grants are subjugated to systemic oppression that limits how the clinic can deliver services. These contracts come with stipulations and regulations that limit what we can and cannot do for our patients in need. We are confronted constantly with the threat of our clinic closing its doors if we do not "follow the rules." I recall feeling anxious when the buzz circulated through the clinic that the auditors were here. Many of us at the clinic would scurry back to our offices to make sure our documentation was compliant. While I understand this might not be any different than being in private practice and following the rules of billing services for insurance reimbursement, the hovering threat of being audited at a moment's notice colored and informed some of the ways we would manage patients who had difficulty keeping appointments.

The clinic where I worked in East Harlem staffed close to 30 clinicians. The patients we served were predominantly long-time residents in East Harlem, most of whom lived in one of the twenty-four public housing buildings in the area. The individuals and families we served were caught in a cycle of intergenerational trauma perpetuated by social and economic oppression. I admired many of my patients who could really stretch a dollar and navigated systems to keep their families fed, clothed, and schooled.

While our clinical approach was psychoanalytic, it was incumbent on us to follow the rules, and we were subjected to frequent audits that threatened our existence as a clinic. I was trained at the clinic to be curious and to understand a patient's inability to keep their appointments consistently. We were taught to be curious about what might be transpiring analytically. However, this stance started to change under the pressure of New York state restructuring their Medicaid regulations in 2010, when the frame became even more rigid. At the time, I was in analytic training and adopting an interpersonal stance informed by Ferenzci—he coined the phrase "*elasticity of technique*," noting that the analyst, "like an elastic band, must yield to the patient's pull, but without ceasing to pull in his own direction, so long as one position or the other has not been conclusively demonstrated to be untenable" (Ferenczi, 1928, p.95, as cited in Bokanowski, 2018, p.49).

> *Tony Bass expands this idea in his paper "When the Frame Does Not Fit the Picture": So while the concept of a frame signifies something that is, by its very nature limiting structure, the work of analysis requires that the structuring function of the frame be capable of constant recalibration in response to the needs of the clinical process. The function of the frame thus appears paradoxical: it delimits and proscribes what can and should happen in the clinical situation, while at the same time facilitating disruption and change in the organization of psychical life.* (Bass, 2018)

At the clinic, most if not all of us were seeing patients who were coming twice a week to treatment for several years. One of the changes in the restructuring is that the more you saw the patient, the less Medicaid would pay the clinic per visit over time, yielding a lower reimbursement rate. Thus, as a clinic, all of the clinicians were tasked with restructuring our treatments by reducing frequency with patients who had been seeing us for some time. The shift in this regard influenced our frame even further due to the pressures of a larger system of Medicaid regulations.

All of this said, I'd like to share two vignettes of how I shifted the frame at a community mental health clinic.

> *An elderly patient of mine was having difficulty keeping her appointments with the psychiatrist. She was being threatened with her case being closed. This patient had difficulty with ambulation and walked with a walker for five long blocks from her home to the clinic. Due to her multiple health ailments and difficulty with appointments, I was able to visit her in the home. Unfortunately, our psychiatrist did not have this flexibility, as his schedule was booked by 15-minute increments throughout the day. One day, she was going to miss her appointment with the psychiatrist. Any time there was a no-show to a psychiatric appointment, it threatened the livelihood of the clinic; we were constantly reminded of this. I ended up sending a car to pick her up to ensure she could keep her appointment.*

> *Another patient who suffered from severe agoraphobia and panic attacks would miss her appointments regularly due to her symptoms and lack of childcare. Due to the institutional pressure of generating revenue, maintaining a caseload of people who showed up regularly was a challenge, specifically with patients with debilitating symptoms. Clinical staff were charged with making sure most of our patients kept their appointments. For those of us who work analytically, the frame often induces heightened symptoms, anxiety, acting out, and enactments. She canceled often and sometimes no-showed; thus, her case was under threat of*

closure. While it might have been helpful to analyze "resistance"—assuming that is what was operating—it seemed more urgent to me to meet her where she was at.

We all expect that our patients will experience some discomfort with the frame (our office, the time, the fee, etc.). In community work, we can also zoom out and consider the real-life circumstances and symptoms that don't match well with specific interventions. With the frame, my patient could barely make it to sessions. She was not getting any better, and her case was about to be closed. Forcing her to come felt sadistic, unempathic, and imposed a specific way of working that did not consider her unique situation. I knew that I had to think outside the box. Initially, we tried to understand what might be happening unconsciously, and while that might have been interesting, lack of childcare and debilitating symptoms were prioritized to engage her in treatment. Over time, her mother was able to babysit. However, my patient's agoraphobia became worse, and she started to miss her appointments again. If we can think of the frame as mutable, we are not exactly abandoning the analytic frame. Rather, we are adjusting it to fit the needs of the patient. Given that we think of the frame in a very particular way, perhaps the symptoms would not get any better because the analyst cannot adjust the frame to meet the patient. Perhaps the analyst does not want to leave the office. The analyst does not want to adopt creative ways to meet the patient wherever they are emotionally and/or physically. This is extremely important in doing community work, where flexibility is key.

When this patient could not leave her apartment, I considered ways in which she had been coming regularly and was motivated to change. I also considered how difficult it is to treat a patient with agoraphobia—regardless of a clinician's theoretical orientation, patients are expected to show up at the clinic. I imagined myself in her shoes, not being able to get help because I could not leave the house. We started to have phone calls to practice grounding techniques—she had longstanding anxiety since she was a child, and daily panic attacks at the thought of leaving home. After receiving approval from the clinic director, we agreed on a plan: I would pick her up at her apartment and walk her to the clinic, where we would have our session. Her mother would pick her up at the clinic when her session was over. The success story in this is that she ended up going back to school by starting remote classes. She was able to identify alternative ways to live a productive life.

In my view, our analytic frame needs to be adjusted and or altered to meet the patient where they are. This concept is drilled into us in graduate school: meet your clients where they are. Yet in practice, we do not always do that, as we associate the analytic frame to physical locations, the time, institutions, clinics, etc. Dr. Bass offers:

> *For the most part, frame recalibrations take place pre-consciously, or sub-symbolically, at the level of micro-adjustments in the analyst's psycho-physical presence and active technique. Active technique (or what I will describe as the inductive dimension of technique) is the part of our technique that is performative rather than receptive or interpretive: it is the aspect of our clinical activity that is embodied in the actuality of our presence (in contrast to what we may represent in the transference, the dream, in a phantasy, and so on). These elements of the analyst's actuality and presence—the way we speak, move, react—have a formative role in the ongoing configuration of the frame, become part of the living body of the frame, before our presence is captured in the web of representation and transferential objectification.*
>
> Bass, 2018, p.105)

While many community mental health clinics aim to serve those who are marginalized, are on public health insurance, and have lives mired by chaos, navigating oppressive systems of care, the institutional nature of a clinic coupled with the inflexibility of a clinical stance can only exacerbate systemic racism and oppression.

As Twemlow and others in this discourse of community psychoanalysis all emphasize, humility and flexibility are key, whether we are working in a community mental health setting or with a hospital to respond to health care worker fatigue. The circumstances in community work are largely unpredictable and require our flexibility to shift and pivot to meet the needs of those we are serving.

If you are to embark on meeting the need for community psychoanalysis, my call to you is a call to action: the frame is not simply an extension of your theoretical orientation; rather, you are the frame. As Dr. Bass and others suggest, the frame is moveable and adjustable, as the frame is established as a "particular kind of contact at the level of shared experience" (Bass, 2018, p.104). In essence, the clinician, analyst, social worker, psychologist is the frame as a dynamic participant who recalibrates the frame to meet the needs of the patient.

The challenge for us today, as enthusiasm for community psychoanalysis grows: how do we, as analysts who are wedded to our analytic stance, pivot? The answer is to pause, look at ourselves, and interrogate our own positionality and intention to provide clinical work in communities.

In sharing my experience, I'm challenging community psychoanalysis to abandon the traditional frame in service of our communities. What does this look like? Some of you in private practice probably already make modifications to your frame to hold your patients. In "Catch Them Before They Fall," Christopher Bollas (2013) describes how his frame is expanded in response to his patients on the verge of decompensation. Without charging more, he increases the frequency of visits and coordinates care via their primary care physician and referrals to psychiatrists. We are the frame that holds an analytic lens and abandons the frames that are systemically perpetuating oppression with the communities that we aim to serve.

As I continue to explore the discourse on frame issues and how our analytic identities inform our work, more questions come to the surface for me: How can we be more intentional in the clinic and take into consideration socio-cultural, socio-political, and socio-economic factors? What cultural and language considerations should we pursue in order to address stigmatization amongst Latinos seeking therapy? How can we be creative and really meet patients and communities where they are in an authentic way that validates their existence?

I hope this paper will motivate us to shift our alliance with our analytic frame (whatever that is for you), which is informed by Euro-centric/white supremacist ideals that foreclose opportunities to engage authentically with people.

If you and your institute, agency, or organization are planning to embark on this endeavor in community psychoanalysis, stretch the frame. Unpack your analytic identity. Abandon the *traditional* frame in the service of community and move it around instead to meet their needs. Be creative and collaborate with the communities you aim to serve. Use your imagination, exercise collaboration, model mutuality, welcome recognition, embrace humility, and be flexible. Above all else, be much more human than otherwise.

REFERENCES

Alpert, J., & Goren, E. (Eds). (2017). *Psychoanalysis, trauma, and community: History and contemporary reappraisals*. Routledge.

Bass, T. (2018). When the frame doesn't fit the picture. In Isaac Tylim & Adrienne Harris (Eds.), *Reconsidering the moveable frame in psychoanalysis: Its function and structure in contemporary analytic theory* (pp.92-128). Routledge.

Bermúdez, G. (2019). Community psychoanalysis: A contribution to an emerging paradigm. *Psychoanalytic Inquiry*, *39*(5), 297-304.

Bokanowski, T. (2018). *The modernity of Sandor Ferenczi: His historical and contemporary importance to psychoanalysis.* Routledge.

Bollas, C. (2013). *Catch them before they fall: The psychoanalysis of breakdown.* Routledge.

Borg, M. B., Jr. (2005). Community analysis: A case study examining transference and countertransference in community intervention. *International Forum of Psychoanalysis*, *14*(1), 5-15.

Christian, C., & Gherovici, P. (Eds.). (2018). *Psychoanalysis in the barrios: Race, class and the unconscious.* Routledge.

Ferenczi, S. (1928). The elasticity of psychoanalytic technique. In *Final contributions to the problems and methods of psychoanalysis* (pp.77-86). Hogarth Press.

Twemlow, S. W. (2013). Broadening the vision: A case for community-based psychoanalysis in the context of usual practice. *Journal of the American Psychoanalytic Association*, *61*(4), 663-690.

Tylim, I., & Harris, A. (Eds.). (2018). *Reconsidering the moveable frame in psychoanalysis: Its function and structure in contemporary psychoanalytic theory.* Routledge.